Recognizing and Responding to Distressing and Distressed Students
Ball State University

Critical Incident Response Team
Information Compiled by Kent Bullis and Jay Zimmerman

This document is in large part an adaptation of the Cornell University Faculty Handbook on students in distress found at:

http://dos.cornell.edu/dos/cms/upload/Total-Book-2.pdf

SECTION 1

RECOGNIZING AND RESPONDING TO STUDENTS IN DISTRESS

As faculty members, you may be the first to notice a student who is experiencing difficulty. You do not have to take on the role of counselor or diagnose a student. You need only notice signs of distress and communicate these to:

- Counseling Center for mental health concerns (285-1736)
- Health Center for physical health concerns (285-8431)
- Office of Student Rights and Community Standards for concerns related to the Code of Student Rights and Responsibilities (285-5036)
- Division of Student Affairs for general inquiries (285-3734)
- University Police for legal or criminal concerns (911 from a campus phone or 285-1111 from your cell phone or other phone)

If you choose, you also may have a direct conversation with the student to gather a little more information, express your concern, and offer resource referral information.

Often, there are indicators that a student is experiencing distress long before a situation escalates to a crisis. To assist our students in maintaining their mental health and maximizing their intellectual growth, it is important to identify difficulties as early as possible. The presence of one of the following indicators alone does not necessarily mean that the student is experiencing severe distress. However, the more indicators you notice, the more likely it is that the student needs help. When in doubt, consult with the Counseling Center at 285-1736.

Faculty members may have concerns about reporting information about students to others. Please see information about the Federal Education Rights and Privacy Act (FERPA) on page 12.

INDICATORS OF DISTRESS

ACADEMIC INDICATORS

• Repeated absences from class, section, or lab

• Missed assignments, exams, or appointments

• Deterioration in quality or quantity of work

• Extreme disorganization or erratic performance

• Written or artistic expression of unusual violence, morbidity, social isolation

• Despair or confusion; essays or papers that focus on suicide or death

• Continual seeking of special provisions (extensions on papers, make-up exams)

• Patterns of perfectionism: e.g., cannot accept themselves if they do not get an A

• Overblown or disproportionate response to grades or other evaluations

BEHAVIORAL AND EMOTIONAL INDICATORS

• Direct statements indicating distress, family problems, or loss

• Angry or hostile outbursts, yelling, or aggressive comments

• More withdrawn or more animated than usual

• Expressions of hopelessness or worthlessness; crying or tearfulness

• Shakiness, tremors, fidgeting, or pacing

• Lack of response to outreach from course staff

• Excessively demanding or dependent behavior

• Expressions of severe anxiety or irritability

PHYSICAL INDICATORS

• Deterioration in physical appearance or personal hygiene

• Excessive fatigue, exhaustion; falling asleep in class repeatedly

• Visible changes in weight; statements about change in appetite or sleep

• Noticeable cuts, bruises, or burns

• Frequent or chronic illness

• Disorganized speech, rapid or slurred speech, confusion

• Unusual inability to make eye contact

• Coming to class bleary-eyed or smelling of alcohol

OTHER FACTORS

• Concern about a student by his/her peers or teaching assistant

• A hunch or gut-level reaction that something is wrong

SAFETY RISK INDICATORS

• Written or verbal statements that mention despair, suicide, or death. Student is making statements about killing or injuring himself or others

• Severe hopelessness, depression, isolation, and withdrawal

• Statements to the effect that the student is "going away for a long time"

***Statements that indicate the student does not have a good grasp on reality, bizarre and disconnected speech or behavior**

THE SITUATION IS AN EMERGENCY IF:

• Physical or verbal aggression is directed at self, others, animals, or property

• The student is unresponsive to the external environment; he or she is

- **incoherent or passed out**
- **disconnected from reality/exhibiting psychosis**
- **displaying unmitigated disruptive behavior**

• The situation feels threatening or dangerous to you

If a student is exhibiting any of these signs, s/he may pose an immediate danger to her/himself. In these cases, you should stay with the student and contact the Counseling Center at 285-1736 (after hours on-call service 747-7330) or walk the student to the Counseling Center in Lucina Hall, Room 320.

If you are concerned about immediate threats to safety, call the Campus Police at 911 from a campus phone or 285-1111 from your cell phone or other phone.

HOW DO YOU KNOW WHEN TO ACT?

You may notice one indicator and decide that something is clearly wrong. Or you may have a "gut-level feeling" that something is amiss. A simple check-in with the student may help you get a better sense of his or her situation.

It is possible that any one indicator, by itself, may simply mean that a student is having an "off" day. However, any one serious sign (a student writes a paper expressing hopelessness and thoughts of suicide) or a cluster of smaller signs (emotional outbursts, repeated absences, and noticeable cuts on the arm) indicates a need to take action on behalf of the student.

DO I NEED TO INFORM ANYONE ELSE?

The purpose of the Critical Incident Response Team (CIRT) is to provide an avenue for members of the Ball State community to confidentially communicate issues of a sensitive and critical nature regarding individual students. CIRT meets regularly to discuss and act on serious incidents pertaining to individual students and to discuss issues and trends that affect Ball State students and the university community. Coordinated by the Associate Vice President for Student Affairs, CIRT is made up of representatives from various

parts of the University (see below). As such, it is in a position to review closely guarded information from many sources and sometimes respond more effectively than those who have limited contact with a student. Behavior which is mildly alarming in the context of very limited exposure to a student may be much more alarming when associated with concerning behavior in multiple settings. If the behavior of a student is concerning, please do not delay discussing it with your supervisor, department chair, or a member of CIRT. If it is isolated behavior, it may not warrant a response. If there are multiple similar reports, your report may help in determining the appropriate course of action. University members can consult with CIRT about students who are problematic, have severe mental health problems or who are disruptive in class or within their department or in the residence halls. The sooner we are able to intervene, the sooner the action can be taken and the situation or behavior addressed.

Current CIRT Members

Lynda Wiley – Associate Vice President for Student Affairs

Cathy Bickel – Associate Director of Housing and Residence Life

Jay Zimmerman – Psychologist in the Counseling Center

Kent Bullis – Director of the Health Center

Robert Fey – Associate Director of Public Safety

Michael Gillilan – Director of Student Rights and Community Standards

Larry Markle – Director of Disabled Student Development

Jacquelyn Buckrop – Assistant to the Provost

SECTION 2

RESPONDING TO STUDENTS IN DISTRESS

CHOOSING A PATHWAY

There are pathways to choose from once you have identified a student in distress: speaking directly with the student or contacting one of the resources listed below.

If you have a relationship or rapport with the student, speaking directly to the student may be the best option. Begin the conversation by expressing your concerns about specific behaviors you have observed.

If you do not really know the student, you may prefer contacting the Counseling Center for consultation.

Your decision about which path to choose also may be influenced by:

- Your level of experience
- The nature or severity of the problem
- Your ability to give time to the situation
- A variety of other personal factors

Consult

- Counseling Center at 285-1736 and for crises or emergencies after hours on-call service at 747-7330
- Department of Public Safety at 911 from a campus phone or 285-1111 from your cell phone or other phone
- Ball State Health Center at 285-8431
- Office of Student Rights and Community Standards at 285-5036
- Office of Victim Services at 285-7844
- Disabled Student Development at 285-5293
- Division of Student Affairs at 285-3734 (general inquiries)

Counseling Center

Services are free and confidential to students. Members of the University community can consult with staff of the Counseling Center about concerns they have for and about the mental health of students and other members of the campus community.

Primary Services Include:

- Individual and group counseling
- Psychiatric consultation
- Career exploration and counseling
- Educational workshops and programs
- Crisis and emergency services
- Consultation
- Testing

Ball State University Department of Public Safety

Members of the campus community to contact Public Safety immediately for assistance with any kind of public safety emergency including crimes in progress, fire, medical emergency, threat to personal safety or security, threat to property, chemical spill, disturbances, etc. Dial 911 from a campus phone or 285-1111 from your cell phone or other phone.

Public Safety can also be helpful in transporting someone to the Emergency Room in a psychiatric emergency.

For information about specific emergencies, please refer to Ball State University Emergency Response Guidelines. This publication specifically addresses in detail a variety of emergencies such as violence on campus, violence in the work place, demonstrations and disturbances, etc.

Health Center

The Health Center is staffed by physicians and Nurse Practitioners during University business hours. They provide evaluation and treatment for a wide variety of physical and mental health problems common to college students. They may be helpful for students in general with medical problems, but they are not an appropriate resource for a true emergency. They see patients on a walk-in basis.

Office of Student Rights and Community Standards

The Office of Student Rights and Community Standards (SRCS) serves as a point of referral for faculty and staff who are working with students whose behavior is disruptive in the learning environment. SRCS can assist in distinguishing between students who need mental health support, referrals to the disciplinary process, or a combination of support mechanisms to assist them to be successful. Intervention options include assistance with referrals to other university

resources (Counseling Center), developing strategies to prevent and reduce disruptive behavior, and intervening directly with a student to end disruption.

Office of Victim Services

The Office of Victim Services (OVS) provides educational and supportive services for the Ball State University community related to sexual assault, relationship violence, and stalking. The program is designed to assist individuals in the recovery process by providing timely information and confidential support and guidance through the campus judiciary and criminal justice systems.

A victim advocate is available after hours for emergencies by calling Public Safety at 285-1111 and requesting the on-call victim advocate be paged.

Disabled Student Development

The role of Disabled Student Development (DSD) is to coordinate service and accommodations for students with disabilities. In doing so, the staff reviews disability documentation, meets with students to determine appropriate accommodations, and works with other areas on campus to implement the accommodations.

TIPS FOR DEALING WITH STUDENTS IN DISTRESS

The Counseling Center's website has information and tips for faculty on dealing with students who present with different kinds of distress. Please consult this information when you think about approaching a distressed student. It includes:

- Tips for Dealing with Distressed Students
  - The Anxious Student
  - How to Talk to Distressed Students
  - General Signs of Distress
  - The Student in Poor Contact with Reality
  - The Student with Sexual Orientation Concerns
  - The Student Sexually Assaulted
  - The Substance Abusing Student
  - The Suspicious Student
  - The Demanding Student
  - The Depressed Student
  - The Grieving Student
  - The Verbally Aggressive Student
  - The Violent or Physically Destructive Student
- How to Make Referrals

Some general tips if you are concerned about a student:

MAKE CONTACT!

You will not be taking on the role of counselor. You need only listen, care, and offer resource referral information.

• Meet privately with the student (choose a time and place where you will not be interrupted.)

• Set a positive tone. Express your concern and caring.

• Point out specific signs you have observed. ("I've noticed lately that you . . .")

• Ask "How are things going for you?"

• Listen attentively to the student's response and encourage him or her to talk. ("Tell me more about that.")

• Allow the student time to tell the story. Allow silences in the conversation. Do not give up if the student is slow to talk.

• Ask open-ended questions that deal directly with the issues without judging. ("What problems has that situation caused you?")

- If there are signs of safety risk, ask if the student is considering suicide. A student who is considering suicide will likely be relieved that you asked. If the student is not contemplating suicide, asking the question will not "put ideas in their head."

- Restate what you have heard as well as your concern and caring. ("What do you need to do to get back on a healthy path?")

- Ask the student what s/he thinks would help.

- Suggest resources and referrals. Share any information you have about the particular resource you are suggesting and the potential benefit to the student.
  ("I know the folks in that office and they are really good at helping students work through these kinds of situations.")

- Avoid making sweeping promises of confidentiality, particularly if the student presents a safety risk. Students who are suicidal need swift professional intervention; assurances of absolute confidentiality may get in the way.

Unless the student is suicidal or may be a danger to others, the ultimate decision to access resources is the students. If the student says, "I'll think about it," when you offer referral information, it is okay. Let the student know that you are interested in hearing how s/he is doing in a day or two. Talk with someone in your college or department about the conversation. Follow up with the student in a day or two.

REFER

Explain the limitations of your knowledge and experience. Be clear that your referral to someone else does not mean that you think there is something wrong with the student or that you are not interested. The referral source has the resources to assist the student in a more appropriate manner.

- Provide name, phone number, and office location of the referral resource. If you are concerned the student will not follow up, offer to walk the student to the Counseling Center for mental health concerns or the Health Center for physical health concerns. Try to normalize the need to ask for help as much as possible. It is helpful if you know the names of staff people and can speak highly of them. Convey the spirit of hopefulness and the information that troublesome situations can and do get better.

- Realize that your offer of help may be rejected. People in varying levels of distress sometimes deny their problems because it is difficult to admit they need help or they think things will get better on their own. Take time to listen to the student's fears and concerns about seeking help. Let the student know that it is because of your concern for him/her that you are referring him/her to an expert.

- End the conversation in a way that will allow you, or the student, to come back to the subject at another time. Keep the lines of communication open. Invite the student back to follow up.

If you have an urgent concern about a student's safety, stay with the student and contact the Counseling Center at 285-1736 (after hours on-call service 747-7330) or walk the student to the Counseling Center in Lucina Hall, Room 320. If you are concerned about immediate threats to safety, call the Campus Police at 911 from a campus phone or 285-1111 from your cell phone or other phone.

Sometimes when students are distressed, they "act out" in ways that are inappropriate or even disruptive to your class. If you have a student who exhibits this kind of behavior, consult with either the Counseling Center or the Office of Student Rights and Community Standards. They will help you and get the student connected with appropriate resources.

FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT (FERPA)

WHAT DOES FERPA COVER?

FERPA limits the disclosure of information from student "education records." Educational records include virtually all records maintained by an educational institution, in any format, that identify a student directly or from which a student's identity could be deduced from descriptive or other information contained in the record, either alone or in combination with other publicly available information.

MAY I DISCLOSE PERSONAL KNOWLEDGE AND IMPRESSIONS ABOUT A STUDENT, BASED ON MY PERSONAL INTERACTIONS WITH THE STUDENT?

Yes. FERPA applies only to information derived from student education records, and not to personal knowledge derived from direct, personal experience with a student. For example, a faculty or staff member who personally observes a student engaging in erratic and threatening behavior is not prohibited by FERPA from disclosing that observation to other "school officials" who have "legitimate educational interests" in the information.

MAY INFORMATION FROM A STUDENT'S EDUCATION RECORDS BE DISCLOSED TO PROTECT HEALTH OR SAFETY?

Yes. FERPA permits the disclosure of information from student education records to appropriate parties either inside or outside of Ball State in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the student or other individuals. For example, if a student sends an email to his resident advisor saying that he has just been diagnosed with a highly contagious disease such as measles, BSU could alert the student's roommates, and perhaps others with whom the student has come in close contact, to urge them to seek appropriate testing and medical care. Safety concerns warranting disclosure could include a student's suicidal statements or ideations, unusually erratic and angry behaviors, or similar conduct that others would reasonably see as posing a risk of serious harm.

WHAT SHOULD I DO IF I AM CONCERNED THAT A STUDENT POSES A THREAT TO SELF OR OTHERS?

If you are concerned that a student may engage in violent behavior, toward self or others, and the threat appears to be imminent, you should contact the campus police immediately at 911 from a campus phone or 285-1111 from a cell phone or other phone. When circumstances permit, you should consult with professionals on campus or associated with the institution that may be able to assess the potential threat, identify resources for the student, and provide information that could assist in deciding on an appropriate course of action. In consultation with appropriate campus resources, such as the Counseling Center (285-1736), Student Rights and Community Standards (285-5036), and Housing and Residence Life (285-8000) and/or the Division of

Student Affairs (285-3734) a decision may then be made to contact a family member, an appropriate off-campus resource, or others.

For more information about FERPA, please visit:

http://cms.bsu.edu/About/AdministrativeOffices/Registrar/ForFacultyandStaff/FamilyEducationalRightsandPrivacyAct.aspx

PROMOTING STUDENT WELL-BEING

FOUNDATIONS FOR SUPPORTING STUDENTS

The college years are a time when a student's focus of life changes from family and home to the college community. Relationships between parents and children change and evolve into relationships between parents and young adults. This evolution varies by culture as well as by individual family. Students are forming a new identity that integrates the many contexts in which they live.

Today's students face intense pressure to succeed. Guidance, support, and help from faculty can ensure the creation of a living-learning environment where students can productively face many issues for the first time.

As faculty and staff, we can better prepare ourselves when we understand the developmental tasks facing students:

• Becoming Autonomous: managing time, money, and other resources, taking care of oneself emotionally and physically, working independently and interdependently, and asking for help.

• Establishing Identity: developing a realistic self-image including an ability to handle feedback and criticism, defining limitations and exploring abilities, and understanding oneself in culture.

• Achieving Competence: managing emotions appropriately, developing and pursuing academic interests, identifying and solving problems, becoming confident and competent, and preparing for careers and life-long learning.

• Understanding and Supporting Diversity: meeting people from diverse backgrounds, encountering differences, and learning to honor the gifts of others.

• Establishing Connection and Community: learning to live respectfully with and among others, and developing skills in group decision-making and teamwork.

HELP STUDENTS UNDERSTAND AND MANAGE THEIR STRESS

The college years can be times of discovery and excitement. Those of us who work with students strive to incorporate those qualities into our teaching and our work. At the same time, the developmental tasks that are particular to the college years can be taxing and difficult. Stress responses can be triggered by positive experiences, such as falling in love or acing an exam, or by negative experiences, such as an unexpected loss, disappointment, or traumatic event. As a positive influence, stress can compel us to action, move us into our "peak performance zone," and bring a sense of excitement or exhilaration to our lives. As a negative influence, it can result

in fatigue, anxiety, and feelings of helplessness. In other words, stress is what our bodies and minds experience as we adapt to a continually changing environment.

Stress occurs on a continuum. To maintain healthy tension, a person must balance the right amount of stimulating challenges with a healthy diet, a consistent sleep schedule, regular exercise, and stress management techniques.

While most students would like to be in the peak performance zone every day, this is not humanly possible. However, by maintaining healthy tension, an individual can access the extra burst of energy and focus needed to achieve peak performance when needed most (e.g., on the day of an exam).

When students perceive that a situation, event, or problem exceeds their resources or abilities, their body reacts automatically with the "fight or flight" response. If this response persists over time or results from a sudden significant change, it can lead to imbalance and health problems such as heart palpitations, insomnia, eating disorders, fatigue, panic disorders, and feelings of hopelessness or depression.

Excessive and/or prolonged levels of stress lead to imbalance and physical, emotional, and social breakdown. This experience of imbalance may present as difficulty concentrating, disorganization, forgetfulness, deterioration in quality or quantity of work, irritability, and exaggerated personality traits. To re-establish balance, the person needs to strengthen his or her stress-management practices, learn new coping strategies, or seek support from others.

If stress is left unchecked, symptoms will worsen, causing severe physical complaints, illness, feelings of anxiety, hopelessness, or depression. The student may be so despondent that s/he skips class or a job, socially withdraws, or takes unnecessary risks with personal safety. At this breakdown point, it is essential for the student to seek professional medical or counseling assistance.

When stress impedes functioning, many people benefit from a combination of lifestyle changes, affirmative interpersonal relationships, counseling, and/or medication. Faculty can support students by reinforcing healthy lifestyle behaviors, addressing classroom behavior or other concerns when first noted, and communicating that seeking assistance when needed is a sign of strength.

To learn more about stress management visit:

http://cms.bsu.edu/campuslife/counselingcenter.aspx

SYNOPSIS OF STUDENT CONCERNS AND CONDITIONS

INTRODUCTION

There is a growing consensus that more students are arriving on college and university campuses with increasingly complex psychological, emotional, and behavioral challenges. Recent studies have indicated that the number of students reporting depression has doubled, the number of suicidal students has tripled, and the number of students seeking services following a sexual assault has quadrupled (Benton, Robertson, Tseng, and Benton, 2003).

Behaviors such as self-injury also are highly prevalent in the student population, with the occurrence of one-time self-injury in nearly one in five students (Whitlock, Eckenrode, and Silverman, 2006). In addition, according to the National Eating Disorders Association (2006), nearly 20 percent of students reported suffering from an eating disorder at some point in their lives. The National College Health Assessment (2006) found that 44 percent of students reported that they were "so depressed it was difficult to function" at some time in the past year, and 9 percent had seriously contemplated suicide, while 1.3 percent actually had attempted suicide.

These results show that colleges and universities are increasingly in need of effective strategies for responding to these complex concerns. Faculty and staff members routinely interact with students who may raise concerns, be disruptive, or even be suicidal, and they need to know the best ways to acknowledge a situation and intervene effectively when a student needs help. Such interactions can be difficult. They often leave faculty and staff members feeling confused or overwhelmed. Nonetheless, there are general guiding principles and support resources available to assist faculty and staff in aiding distressed or distressing students.

This section briefly explores those principles and outlines support resources available at Ball State as well as books, films, and informational resources on the Internet. Please use this section as a starting place to gather information and to increase your understanding of these issues as we all work to create a more caring community.

SECTION I: ACADEMIC CONCERNS

Responding to Disturbing Content in Written or Artistic Work by a Student

Faculty members and teaching assistants sometimes find disturbing comments in the written work of students, such as:

• disclosure of personal trauma or abuse

• references to suicidal thoughts or severe depression

• violent or morbid content that is disturbing or threatening

• sexual content that is disturbing or excessively graphic

• bizarre or incoherent content

• disclosure of severe problems with alcohol or drug abuse

Such writing may simply indicate a dramatic or unusual style but may also suggest psychological or emotional problems or possible danger to self or others. It also may indicate a bid for attention or a cry for help.

The following guidelines may help determine whether there is reason for concern and how best to respond.

In your written comments:

- Acknowledge the content with comments like, “That must have been hard for you.”
- Invite discussion with comments like, “Sounds like that was difficult for you-do you have someone to talk with about this?” or, “If you would like to talk about this, stop by after class or during office hours.” An email to the student is also an excellent way to communicate your initial concerns and ask the student to come to talk with you.
- Consider the student’s behavior in class and whether that reinforces or decreases your concern. For example, writing about suicide is more concerning if the student appears sad, withdrawn, or angry.
- Consult with your supervisor, department chair, or contact the Counseling Center for consultation to determine if referral, immediate intervention, or outreach to the student is indicated. The counselor may also provide suggestions about how to talk with the student.
- If you feel threatened or uneasy, do not meet with the student alone. Consult your supervisor, department chair, Public Safety, and/or the Counseling Center and consider having another person at the meeting or other options to ensure safety.
- When meeting with the student, ask about the inspiration for the work, to provide a context and see if the student has been influenced by similar writings (e.g., Stephen King.) Consider asking the student directly if s/he is thinking about suicide or other destructive behavior.
- Know your limits. Remember, your role is as staff or faculty member, not counselor. Even a brief acknowledgment or expression of concern can be very meaningful and helpful to a student; however, the conversation does not need to be lengthy if that is beyond your limits.

If you have questions about the content of emails, essays or other written or verbal communication from students, consult with the Counseling Center or the Office of Student Rights and Community Standards.

Resources:

Responding When a Life Depends on It: What to Write in the Margins When Students Self-disclose by Marilyn J. Valentino, http://caps.ucdavis.edu/resources/staff/margin/Margin.pdf

The Student Who is Struggling Academically

Some students will struggle at Ball State. When students do not succeed at Ball State, the reason is rarely that they are intellectually incapable of doing the work; something outside school gets in their way: immaturity, lack of motivation or discipline, mismatch with program, alcohol, illness, emotional problems, family issues, or financial difficulties.

Many students who struggle academically are doing so for the first time in their lives. Their reactions to not doing well in a course vary widely. Some students will withdraw into silence. Some will complain loudly that a poor grade will ruin their lives, derailing their plans for medical, law, or business school. Some will doggedly persevere. No matter their response, it is vital that you give students the grades they earn. If you announce on your syllabus an attendance policy, you should abide by it. If your syllabus states that you will not accept late work, do not accept it. Maintaining academic standards is critical for your sake, for the sake of the students, and for the sake of the university.

The University has numerous resources equipped to assist students through their struggles. You need to connect students with these support services or consult with them about how best to intervene with and help the student.

As you become aware that a student in your course or one of your advisees is struggling, the most effective way to assist the student is talk with the student and connect them with the appropriate office or call that office and consult about steps to take.

The Student Who Needs a Major

Some students come to Ball State with fairly clear ideas about which major(s) they will pursue. Others are unsure. Some, once they start exploring the breadth of opportunities and programs available discover exciting options they had not thought about. Some end up adding a major or minor to their original plan, but some may completely change academic direction. Students can get assistance about majors from academic advisors, the Career Center and/or the Counseling Center. Encourage them to talk with people or visit the websites of these offices.

The Student Who Needs Career Direction

Many students enter Ball State uncertain about their career direction and may benefit from career exploration as early as their freshman year. Many others change their plans, often several times. The Career Center helps with exploring career options and advising about career interests, internships, special events, career classes, and career workshops.

As students approach graduation, they may experience a sense of fear about the prospect of leaving school and getting a career position or selecting a graduate school. Some start to approach this transition by gathering information and exploring options as freshmen, sophomores, and juniors, while others wait until their senior year. Students may feel frustrated if they cannot find a position of their choosing, especially when the economic climate adds to the uncertainty. Students may feel especially anxious, or even depressed, when employers or graduate schools or internships make their choices. The on-campus recruiting program results in jobs for many but it also creates worry and stress for many others-those who are unsuccessful in using this service and those whose interests do not coincide with the options presented.

SECTION 2: PHYSICAL CONCERNS

The Verbally Aggressive and Potentially Violent Student

It is very difficult to predict aggression. When a student is faced with a frustrating situation that is perceived to be insurmountable, the student may become angry and direct that anger toward others. Yet, in spite of recent high-profile tragedies, a student acting out violently is a fairly rare event.

Developmentally, stressors may increase for a student who has coped marginally before leaving home. Additionally, the access to drugs or alcohol for some may increase the propensity for more aggressive behavior. Certain social situations also may elicit aggressive responses. In some cases, the aggression may be indicative of the onset of a mental health disorder.

Violence cannot be predicted, but there are some indicators that suggest a person may have the potential for violence. These include having a prior history of family violence or abuse, volatility, or inability to control aggressive impulses due to organic or learned behavior. Unfortunately, in dealing with individuals, you do not always know the historical or immediate background of a particular student. Therefore, it is important to be able to understand your own sense of safety and to ask for assistance if you feel threatened.

What you can do:

• Use a time-out strategy (ask the student to reschedule a meeting with you after s/he has more time to think.)

• Stay calm and set limits (explain clearly and directly what behaviors are acceptable, e.g., “You certainly have the right to be angry, but breaking things is not OK.”)

• Enlist the help of a co-worker or supervisor (avoid meeting alone or in a private office with the student.)

• If you feel it is appropriate to continue meeting with a distressed student, remain in an open area with a visible means of escape (keep yourself at a safe distance, sit closest to the door, and have a phone available to call for help.)

• Assess your level of safety and be cognizant of your intuition. Call Public Safety at 911 from a campus phone or 285-1111 from a cell phone or other phone if you feel the student may harm him/herself, someone else, or you.

SECTION 3

MENTAL HEALTH CONCERNS

What is Mental Illness?

Mental illnesses and psychological suffering are conditions that arise out of a complex mix of psychological, social, and biological influences that disrupt a person's thinking, feeling, mood, ability to relate to others, and daily functioning. Mental illness is a broad descriptive category that can include conditions like major depression, schizophrenia, bipolar disorder, obsessive-compulsive disorder (OCD), panic disorder, and post-traumatic stress disorder (PTSD.) A variety of psychological conditions and mental illnesses can affect persons of any age, race, religion, or income. These conditions are not the result of personal weakness, lack of character or intelligence, or poor upbringing.

The good news about these conditions is that there is a wide variety of treatments available and those treatments are very successful. Most people diagnosed with a mental illness can experience relief from their symptoms by actively participating in an individual treatment plan. Effective treatment often involves a combination of psychotherapy, medication, and social support. A healthful diet, exercise, and sleep contribute to overall health and wellness and are essential in recovering from these conditions.

Below are some important facts about mental illness and treatment:

• Mental illnesses can strike individuals in the prime of their lives, often during the college years.

• Without treatment, the consequences of these conditions for the individual and society are staggering: unnecessary disability, unemployment, substance abuse, homelessness, inappropriate incarceration, suicide, and wasted lives.

• The best treatments for these conditions are highly effective; depending on the condition and the treatment, between 70 and 90 percent of individuals have significant reduction of symptoms and improved quality of life.

• Early identification and treatment are essential; ensuring access to the treatment and recovery supports accelerates recovery and minimizes further harm.

• Stigma erodes confidence that these conditions are real and treatable. All of us cannot afford to allow stigma and a sense of hopelessness to set in and erect attitudinal, structural, and financial barriers to effective treatment and recovery. We must all work to take these barriers down.

Resources:

HALF OF US-Information and true stories from young people facing distress and the stigma that comes with the challenge of a mental illness, www.halfofus.com

National Alliance on Mental Illness (NAMI), www.nami.org

National Institute of Mental Health, www.nimh.nih.gov

Recovery From Mental Illness

Successful recovery from a mental illness or other psychological condition is a process that involves learning about the condition and the treatments that are available; empowering oneself through the support of peers, family members, and the Ball State community; and taking action to manage the illness. One of the potential tragedies of mental illness is that treatments exist that can give people back their lives and their self-respect, but they do not make use of them.

The National Alliance on Mental Illness's In Our Own Voice, a live presentation by persons who have experienced mental illness, offers living proof that recovery from mental illness is an ongoing reality. Science has greatly expanded our understanding and treatment. Once forgotten in mental institutions, individuals now have a real chance at reclaiming full, productive lives, but only if they have access to the treatments, services, and programs so vital to recovery as follows:

• Newer classes of medications and improved psychotherapy protocols can better treat individuals with mental illnesses. Eighty percent of people suffering from bipolar disorder and 65 percent of people with major depression respond quickly to treatment; additionally, 60 percent of people with schizophrenia can be relieved of acute symptoms and learn to manage their environment.

• The involvement of persons with mental illness and their family members in all aspects of planning, organizing, financing, and implementing delivery of services results in more responsiveness and accountability and far fewer grievances.

Students may need a leave of absence from Ball State to care for themselves before they address academics concerns. This often can be a very good decision on the part of students that can allow them the time they need to get better and return. If a student needs to discuss this option, please refer him/her to the Ombudsperson, located in the Division of Student Affairs.

Resources:

National Alliance on Mental Illness Advocate E-Newsletter, www.nami.org/ADVTemplate.cfm?Section=Advocate_Magazine&template=/ContentManagement/ContentDisplay.cfm&ContentID=67415

The Jed Foundation: With help from organizations like this, the cultural shift-from a treatment-only to a broader public health model-is happening at colleges all across the country, www.jedfoundation.org/professionals

I Am Not Sick, I Don't Need Help: Helping the Seriously Mentally Ill Accept Treatment, 2nd ed. Amador, X. 2007.

Depression

Depression is a broad category that can encompass feelings of sadness, difficulties adjusting with a depressed mood, and a major depressive disorder (MDD). MDD affects millions of Americans every year and is the leading cause of disability in the U.S. for the ages of 15-44 (NIMH, 2006). The lifetime prevalence of MDD is 6.2 percent. Unlike the normal emotional experiences of sadness, loss, or passing mood states, MDD is persistent and can significantly interfere with an individual's thoughts, behavior, mood, activity, and physical health. MDD affects women twice as often as men for reasons that are not fully understood. More than half of individuals who experience a single episode of MDD will continue to have episodes that occur as frequently as once or even twice a year. Without treatment, the frequency of MDD as well as the severity of symptoms tend to increase over time. Left untreated, individuals with MDD often contemplate suicide and sometimes act on those thoughts.

Symptoms of MDD

The onset of the first episode of major depression may not be obvious if it is gradual or mild. The symptoms of MDD characteristically represent a significant change from how a person normally functioned.

The symptoms include:

• persistently sad or irritable mood

• pronounced changes in sleep, appetite, and energy

• difficulty thinking, concentrating, and remembering

• physical slowing or agitation

• lack of interest in or pleasure from activities that were once enjoyed

• feelings of guilt, worthlessness, hopelessness, and emptiness

• recurrent thoughts of death or suicide

• persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders, and chronic pain

When several of these symptoms of depressive illness occur at the same time, last longer than two weeks, and interfere with ordinary functioning, professional treatment is needed.

How is MDD treated?

Although MDD can be devastating, it is highly treatable. Between 80 and 90 percent of those diagnosed with MDD can be effectively treated and return to their daily activities. Many types of treatment are available, and the type chosen depends on the individual and the severity and patterns of his or her illness.

Psychotropic medication is one proven treatment. It often takes two to four weeks for antidepressants to start having an effect, and six to twelve weeks for antidepressants to have their full effect.

Psychotherapy is another effective treatment and has been shown to be particularly effective in relapse prevention after medication has been discontinued. Cognitive-behavioral therapy (CBT) interpersonal therapy (IPT) and behavioral activation all have been found to effectively treat MDD.

More severe MDD may be more likely to respond to a combination of psychotherapy and medication. Additionally, peer education and support can promote recovery. Attention to lifestyle, including diet, exercise, and smoking cessation, can result in better health, including mental health.

Resources:

Understanding Major Depression and Recovery, www.nami.org/Template.cfm?Section=By_Illness&template=/ContentManagement/ContentDisplay.cfm&ContentID=61084

The Up and Down Show-Separating Fact from Fiction, www.depressionisreal.org/podcast

National Institute of Mental Health, www.nimh.nih.gov/health/publications/depression/completepublication.shtml

Esperanza-Hope to Cope with Anxiety and Depression, www.hopetocope.com/default.html

The Depression Sourcebook. Quinn, B.P. 1997.

The Peace of Mind Prescription: An Authoritative Guide to Finding the Most Effective Treatment for Anxiety and Depression. Charney, D. S., M.D. and Nemeroff, C.B., M.D., Ph.D. with Braun, S. 2004.

Bipolar Disorder

Bipolar disorder, or manic depression, is an illness that causes extreme shifts in mood, energy, and functioning. These changes may be subtle or dramatic and typically vary greatly over the course of a person's life as well as among individuals. Approximately 4 percent of the population in the U.S. suffers from bipolar disorder. It affects men and women equally.

Bipolar disorder is characterized by episodes of mania and depression that can last from days to months. Bipolar disorder often begins in adolescence or early adulthood and occasionally even in childhood. Most people generally require some sort of lifelong treatment. While medication is one key element in successful treatment of bipolar disorder, psychotherapy, support, and education about the illness also are essential components of treatment.

What are the symptoms of mania?

Mania is the word that describes the activated phase of bipolar disorder. The symptoms of mania may include:

• either an elated, happy mood or an irritable, angry, unpleasant mood

• increased physical and mental activity and energy

• racing thoughts and flight of ideas

• increased talking, more rapid speech than normal

• ambitious, often grandiose plans

• risk taking

• impulsive activity such as spending sprees, sexual indiscretion, and alcohol abuse

• decreased sleep without experiencing fatigue

• extreme agitation or aggressive behavior

• hypersexuality or sexual statements

• on occasion, psychotic symptoms including paranoia, hallucinations or delusions, especially of a paranoid or grandiose nature

What are the symptoms of depression?

Depression is the other phase of bipolar disorder. Symptoms of depression may include:

• loss of energy

• prolonged sadness

• decreased activity and energy

• restlessness and irritability

• inability to concentrate or make decisions

• increased feelings of worry and anxiety

• less interest or participation in, and less enjoyment of, activities normally enjoyed

• feelings of guilt and hopelessness

• thoughts of suicide

• change in appetite or sleep (either more or less)

How is bipolar disorder treated?

Bipolar disorder is a treatable and manageable illness. After an accurate diagnosis, most people can achieve an optimal level of wellness. Medication is an essential element of successful treatment for people with bipolar disorder. In addition, psychosocial therapies including cognitive-behavioral therapy, interpersonal therapy, family therapy, and psychoeducation are important to help people understand the illness and to internalize skills to cope with the stresses that can trigger episodes. Changes in medications or doses may be necessary as well as changes in treatment plans during different stages of the illness.

Resources:

Guide to Understanding Bipolar Disorder and Recovery, www.nami.org/Template.cfm?Section=By_Illness&template=/ContentManagement/ContentDisplay.cfm&ContentID=63360

NAMI's Living with Bipolar Disorder community: support, targeted information, and connections with people who understand, www.nami.org/Template.cfm?Section=By_Illness&template=/ContentManagement/ContentDisplay.cfm&ContentID=38852

Depression and Bipolar Support Alliance: organization to improve lives of people living with mood disorders through support, education, and advocacy,

www.nami.org/ContentManagement/ContentDisplay.cfm?ContentID=7253

National Institute of Mental Health: information from the NIH institute on bipolar disorder, www.nimh.nih.gov/health/topics/index.shtml

An Unquiet Mind. Jamison, K. R. 1995.

One Hundred Questions and Answers about (Bipolar Manic- Depressive) Disorder. Albrecht, A.T., M.D. and Herrick, C., M.D. 2007.

The Student Who Feels Suicidal

Suicide is the second leading cause of death among college students, killing more young people between the ages of 18 and 24 than all physical illnesses combined. Academic, financial, and social pressures can overshadow the quest for knowledge that can lead to a life of achievement, fulfillment, and happiness. Suicide attempts are often triggered by losses of important relationships or losses related to the hopes and expectations of the students, their families, or their communities.

Suicidal behavioral states are time limited. Suicidal thoughts occur when a path leading to a tolerable existence does not appear to be available. During the crisis, a person's coping mechanisms are suspended. The rise in energy during the crisis, although signified by emotional turmoil, also can lead to the information, insight, and motivation necessary to resolve the conflict.

Some students who contemplate killing themselves have a mental illness and some do not. A percentage of suicides and attempts are impulsive. Students who are vulnerable to suicidal states may be more at risk during college years. Away from home, isolated from familiar support systems, and experiencing pressure to perform, these students may become overwhelmed and begin to feel hopeless about their present situation or future. Major mental illnesses can develop during a person's early 20s; a student who is unaware of the cause of his/her new-found symptoms may turn to suicide to end the confusion and pain.

A student may be contemplating suicide if he or she is ruminating about suicide and becoming increasingly isolated. Individuals are more at risk for suicide if there is a history of suicide or major depression in their family or if they have had previous attempts. Additionally, students are at more immediate risk if they have a specific plan for suicide. Students are more likely to act on their hopeless feelings while under the influence of alcohol or drugs. A suicide note, email, video, or web page (e.g., on Facebook) should be considered as very worrisome, spurring faculty members to make an urgent referral.

Warning signs may include:

• stress due to loss, illness, financial instability, academic difficulty

• loss of interest in academics, missing class or assignments, failing exams

• inability to concentrate

• isolation, withdrawal from others and their support

• deterioration in hygiene

• change in eating or sleeping habits

• presence of a plan to harm self

• specific means available to carry out the plan

People who contemplate suicide are often ambivalent about killing themselves and are often willing to get help through counseling when a faculty member facilitates the process for them. Cryptic or indirect messages left by students should not be ignored. Some students who are severely depressed do not have the emotional energy to seek help and use cryptic messages to reach out: "I won't be bothering you much longer," "It'll all soon be over," or "Time is running out."

Students who are feeling suicidal are often relieved when someone finally asks them, "Are you thinking of killing yourself?" They no longer have to struggle with their feelings alone. Asking them if they are suicidal will not "put the thought" into their head.

Students who are suicidal are helped by counseling and sometimes medication. Some may be hospitalized for a short time to enable medications to take effect, to ensure their safety in the short run, and to help them connect with resources to deal with the issues they face.

If you are concerned about immediate threats to safety, call 911 from a campus phone or 285-1111 from a cell phone or other phone.

Resources:

Night Falls Fast: Understanding Suicide. Jamison, K. R. 1999.

After Suicide Loss: Coping with Your Grief. Baugher, B. and Jordan, J. 2002.

National Suicide Prevention Hotline 1-800-273-8255

Anxiety, Panic Disorder, and Phobias

Anxiety is a natural response to stress with symptoms ranging from increased heart rate and loss of appetite to a general nervous feeling. The anxiety can be of a general nature, or the anxiety can be specific, such as social anxiety or a phobia.

Students may feel anxiety from a number of sources. Some are separated from their family and friends for the first time. Some have never shared a room with someone they don't know. Some find that while they were the star of their high school, they are now "just" average. Some come to the university already having experienced difficulties and now are on their own in managing them. Anxiety may interfere with the student's academic functioning, causing the student to lose the ability to concentrate, to process information, to comprehend, or to memorize material effectively. Anxiety may contribute to difficulty in managing time and tasks effectively.

Students may be helped through relaxation and stress management techniques. Guidance in study skills, time management, and handling procrastination can help in the academic arena. Others may find help with a period of counseling.

Panic Disorder

A person who experiences recurrent panic attacks, at least one of which leads to a month or more of increased anxiety or avoidant behavior, is said to have panic disorder. Panic attacks are characterized by palpitations, sweating, trembling, sensations of shortness of breath, feelings of choking, chest pain, feeling dizzy, fear of losing control, fear of dying, numbness, and chills or hot flashes. Panic disorder is an acquired fear of certain bodily sensations, and agoraphobia is a behavioral response to the anticipation of these sensations.

Panic attacks can occur in anyone. It is estimated that 2 to 5 percent of Americans have panic disorder. Severe stress, such as the death of a loved one, can bring on panic attacks. Panic attacks typically last about 10 minutes, but may be a few minutes shorter or longer. During the attack, the physical and emotional symptoms increase quickly in a crescendo-like way and then subside. A person may feel anxious and jittery for many hours afterward.

What are the symptoms of panic disorder?

To be diagnosed as having panic disorder, a person must experience at least four of the following symptoms during a panic attack: sweating, hot or cold flashes, choking or smothering sensations, racing heart, labored breathing, trembling, chest pains, faintness, numbness, nausea, disorientation, and feelings of dying, losing control, or losing one's mind.

How is panic disorder treated?

Cognitive behavioral treatment (CBT) is the treatment of choice and can be performed in any outpatient setting or in primary care settings. The combination of medication (specifically high-

potency benzodiazepines) with CBT treatments is contraindicated and may contribute to relapse. The goal of CBT is to help the person engage in monitoring of his/her experiences and replace statements like ”I feel horrible; my whole body is out of control” with “Anxiety level 6. Symptoms are dizziness and shortness of breath. Episode lasted 5 minutes.” CBT also involves giving the person more understanding of the body’s anxiety systems, teaching effective breathing, decreasing sensitivity to bodily sensations, and having the person examine beliefs and self-statements.

What are phobias?

Phobias are irrational, involuntary, and inappropriate fears of (or responses to) ordinary situations or things. People who have phobias can experience panic attacks when confronted with the situation or object about which they feel phobic. A category of symptoms called phobic disorder falls within the broader field of anxiety disorders.

Many people with phobias or panic disorder “fear the fear” or worry about when the next attack is coming. The fear of more panic attacks can lead to a very limited life. People who have panic attacks often avoid the things they think triggered the panic attack and then stop doing the things they used to do or the places they used to go.

Resources:

Anxiety Disorders Association of America (ADAA): national, non- profit organization dedicated to informing the public, providers, and policy-makers about anxiety disorders, www.adaa.org

National Institute of Mental Health: information from the NIH institute on panic disorder, www.nimh.nih.gov/health/topics/panic-disorder/index.shtml

Beyond Anxiety & Phobia: A Step-by-Step Guide to Lifetime Recovery. Bourne, E.J. 2001.

Adapted from information from the National Alliance on Mental

Illness (NAMI) and National Institute of Mental Health (NIMH)

Post-Traumatic Stress Disorder (PTSD)

Living through any traumatic event, such as a natural disaster (e.g., a hurricane, flood), physical abuse, sexual assault, war, or a severe car crash, can trigger feelings of helplessness and fear, sometimes leading to an anxiety disorder called post-traumatic stress disorder (PTSD). People with PTSD find it difficult to function in their daily life and may:

• have intrusive thoughts, memories, or bad dreams about the event

• feel anxious, guilty, or depressed

• feel numb and distance themselves from loved ones

• replay the experience over and over in their mind

While not everyone exposed to a traumatic event will experience PTSD, about 7-8 percent of the U.S. population will experience PTSD symptoms at some point in their lives. For students who are returning war veterans or who have experienced another traumatic event, the signs of PTSD may appear soon after the event or months or even years later. Those with PTSD may experience loss of memory about the traumatic event or focus on it considerably. They may experience sleep problems, such as difficulty falling asleep and staying asleep, and turn to alcohol or other drugs and see their relationships deteriorate.

PTSD is one of the most difficult disorders to treat. The sooner it is recognized and treated, the more likely a person will experience relief from his or her symptoms. The most effective treatments include components that have the person relive the trauma in his or her imagination, while using deep muscle relaxation and thinking about the event in different ways. Medications also offer modest relief from the anxiety and depression that often occur with PTSD.

Resources:

National Center for Post Traumatic Shock: www.ncptsd.va.gov/ncmain/index.jsp

National Institute of Mental Health:
www.nlm.nih.gov/medlineplus/posttraumaticstressdisorder.html

National Alliance on Mental Illness: www.nami.org

Obsessive-Compulsive Disorder (OCD)

Obsessive-compulsive disorder (OCD) is characterized by recurrent obsessions and/or compulsions that interfere substantially with how a person functions. Within any given year, approximately 1 percent of the U.S. population is believed to meet the criteria for OCD.

Obsessions are intrusive, irrational thoughts-unwanted ideas or impulses that repeatedly well up in a person's mind. Again and again, the person experiences disturbing thoughts, such as "My hands must be contaminated; I must wash them" or "I may have left the gas stove on." The person may be ruled by numbers, fear s/he will harm others, or concerned with body imperfections. On one level, the sufferer knows these obsessive thoughts are irrational. On another level, s/he fears these thoughts might be true. Trying to avoid such thoughts creates greater anxiety.

Compulsions are repetitive rituals such as hand washing, counting, checking, hoarding, or arranging. An individual repeats these actions in attempts to reduce the anxiety brought on by obsessions. People with OCD feel they must perform these compulsive rituals or something bad will happen. Most people occasionally have obsessive thoughts or compulsive behaviors. OCD occurs when the obsessions or compulsions are severe enough to cause serious distress, be time-

consuming (compulsions occurring more than an hour each day), and interfere with daily functioning.

People with OCD often attempt to hide their problem rather than seek help. They are remarkably successful in concealing their obsessive-compulsive symptoms from friends and co- workers. An unfortunate consequence of this secrecy is that people with OCD generally do not receive professional help until years after the onset of their disease.

What treatments are available for OCD?

The treatments found to produce the best results for OCD include exposure and ritual prevention and cognitive therapy. Exposure and ritual prevention expose the person to the thought or situation that produces the anxiety and then prevent the ritual response. Cognitive therapy is effective in addressing beliefs often found in OCD like having a thought is the same as performing an action, failing to prevent harm is the same as causing harm, and that one can control one's thoughts. These approaches have been found to be effective in 75 to 85 percent of cases with strong relapse prevention.

Resources:

The Boy Who Couldn't Stop Washing. Rapoport, J, M.D. 1991.

Freedom from Obsessive-Compulsive Disorder: A Personalized

Recovery Program for Living with Uncertainty. Grayson, J. 2003.

Schizophrenia

Schizophrenia is a serious mental illness that affects well over two million American adults, about 1 percent of the population age 18 and older. Although it is often feared and misunderstood, schizophrenia is a treatable condition. Schizophrenia often interferes with a person's ability to think clearly, distinguish reality from fantasy, manage emotions, make decisions, and relate to others. The first signs of schizophrenia typically emerge in the teenage years or early 20s, often later for females. Most people with schizophrenia contend with the illness chronically or episodically throughout their lives and are often stigmatized by lack of public understanding about the disease. Schizophrenia is not caused by bad parenting or personal weakness. A person with schizophrenia does not have a "split personality," and almost all people with schizophrenia are not dangerous or violent toward others while they are receiving treatment.

What are the symptoms of schizophrenia?

No one symptom positively identifies schizophrenia. Symptoms of this illness also can be found in other mental illnesses. For example, psychotic symptoms may be caused by the use of illicit drugs, may be present in individuals with Alzheimer's disease, or may be characteristics of a

manic episode in bipolar disorder. With careful assessment and understanding of the illness over time, a correct diagnosis can be made.

The symptoms of schizophrenia are generally divided into three categories - Positive, Negative, and Cognitive.

Positive symptoms include delusions and hallucinations. The person has lost touch with reality in certain important ways. "Positive" refers to having overt symptoms that should not be there. Delusions cause individuals to believe that people are reading their thoughts or plotting against them, others are secretly monitoring and threatening them, or they can control other people's minds. Hallucinations cause people to hear or see things that are not present.

Negative symptoms include emotional flatness or lack of expression, an inability to start and follow through with activities, speech that is brief and devoid of content, and a lack of pleasure or interest in life. "Negative" does not refer to a person's attitude but to a lack of certain characteristics that should be there.

Cognitive symptoms pertain to thinking processes. For example, people may have difficulty with prioritizing tasks, certain kinds of memory functions, and organizing their thoughts. A common problem associated with schizophrenia is the lack of insight into the condition itself. This is not a willful denial but rather a part of the mental illness itself. Such a lack of understanding, of course, poses many challenges for loved ones seeking better care for the person with schizophrenia.

How is schizophrenia treated?

While there is no cure for schizophrenia, it is a treatable and manageable illness. However, people sometimes stop treatment because of medication side effects, lack of insight, disorganized thinking, or because they feel the medication is no longer working. People with schizophrenia who stop taking prescribed medication risk relapsing into an acute psychotic episode. It's important to realize that the needs of the person with schizophrenia may change over time. Below are examples of supports and interventions:

Hospitalization: Individuals who experience acute symptoms of schizophrenia may require intensive treatment, including hospitalization. Hospitalization is necessary to treat severe delusions or hallucinations, serious suicidal thoughts, an inability to care for oneself, or severe problems with drugs or alcohol. Hospitalization may be essential to protect people from hurting themselves or others.

There are medications that can help treat schizophrenia and in combination with psychotherapy can help people manage their illness and life.

Family Support: Caregivers benefit greatly from the National Alliance on Mental Illness (NAMI) Family-to-Family education program, taught by family members who have the knowledge and the skills needed to cope effectively with a loved one with a mental disorder.

Resources:

NAMI's Living with Schizophrenia Community: support, targeted information, and connections with people who understand, www.nami.org/Template.cfm?Section=By_Illness&template=/ContentManagement/ContentDisplay.cfm&ContentID=38851

National Institute of Mental Health: information from the NIH institute on schizophrenia, www.nami.org/ContentManagement/ContentDisplay.cfm?ContentID=22576

Texas Medication Algorithm Project (TMAP): guide to treatment decisions for schizophrenia, major depression, and bipolar disorder, www.nami.org/ContentManagement/ContentDisplay.cfm?Content ID=7283

Schizophrenia: Public Attitudes, Personal Needs, www.nami.org/sstemplate.cfm?section=SchizophreniaSurvey

The Center Cannot Hold: My Journey Through Madness. Saks, E.R. 2007.

The Complete Family Guide to Schizophrenia: Helping Your Loved

One Get the Most Out of Life. Mueser, K.T. and Gingerich, S. 2006.

Surviving Schizophrenia: A Manual for Families, Patients, and Providers. 5th ed. Torrey, E. and Fuller 2006.

A Beautiful Mind: A Biography of John Forbes Nash Jr., winner of the Nobel Prize in Economics, 1994. Nasar, Sylvia. 1998. A Beautiful Mind, a film starring Russell Crowe and Ed Harris.

Canvas, a film about schizophrenia and family relationships, www.canvasthefilm.com

Attention-Deficit/ Hyperactivity Disorder

Attention-deficit/hyperactivity disorder (ADHD) is an illness characterized by inattention, hyperactivity, and impulsivity. The most commonly diagnosed behavior disorder in young persons, ADHD affects an estimated 3 to 5 percent of young people. Although ADHD is usually diagnosed in childhood, it is not limited to children - ADHD often persists into adolescence and adulthood and is frequently not diagnosed until later years.

There are actually three types of ADHD, each with different symptoms: predominantly inattentive, predominantly hyperactive/impulsive, and combined. The most common type of ADHD has a combination of the inattentive and hyperactive/impulsive symptoms.

Those with the predominantly inattentive type often:

• fail to pay close attention to details or make careless mistakes in schoolwork, work, or other activities

• have difficulty sustaining attention to tasks or leisure activities

• do not seem to listen when spoken to directly

• do not follow through on instructions and fail to finish schoolwork, chores, or duties in the workplace

• have difficulty organizing tasks and activities

• avoid, dislike, or are reluctant to engage in tasks that require sustained mental effort

• lose things necessary for tasks or activities

• are easily distracted by extraneous stimuli and are forgetful in daily activities

Those with the predominantly hyperactive/impulsive type often:

• fidget with their hands or feet or squirm in their seat

• leave their seat when remaining seated is expected

• move excessively or feel restless during situations in which such behavior is inappropriate

• have difficulty engaging in leisure activities quietly

• talk excessively and blurt out answers before questions have been completed

• have difficulty awaiting their turn and interrupt others

How is ADHD treated?

Many treatments-some with good scientific basis, some without-have been recommended to treat ADHD. The most proven treatments are medication and behavioral therapy.

Resources:

Scattered Minds. Adler, L. 2006.

ADHD in Adults. Barkley, Russell, Murphy, and Fischer. 2008.

Survival Guide for College Students with ADHD or LD. Nadeau, K. 2006.

Asperger's Syndrome/Autism

Asperger's Syndrome (AS) is a neurological disorder often referred to as High Functioning Autism. Individuals with AS often have unusually strong, narrow interests and average to superior intellect. Many students with AS will not self-identify and of those who do, not all will require formal classroom accommodation. Individuals with AS are most comfortable with predictable routine; conversely they may be quite disturbed by changes in familiar and expected routines, whether in or outside the classroom.

Students with AS may exhibit deficits in one or more domains of language, communication, social interaction and behavior. Some individuals will also have associated conditions. Common characteristics of individuals with AS are:

Language/communication:

• very literal - does not understand metaphors, idioms, hyperbole

• does not get jokes, nuance, subtleties of language

• uses odd phrases

• doesn't understand gestures, facial expressions, or voice tones/inflection

• difficulty modulating own voice (often loud)

• difficulty understanding instructions (but may appear to understand)

• talks about what s/he knows, usually facts

Social interaction:

• difficulty making eye contact

• seems distant or detached

• finds it difficult to make friends, prefers to spend time alone

• difficulty initiating, maintaining, and ending a conversation

• does not understand social norms, mores, cues, or concept of personal space

• does not understand other people's emotions

• difficulty managing own emotions

Behavior:

• interrupts the speaker; attempts to monopolize conversation

• becomes tangential in answering questions

• engages in self-stimulating behavior (rocking, tapping, playing with “stress toys”)

• poor self care (eating, sleeping, appearance, or hygiene)

• rigid fixation on certain concepts, objects, patterns, actions (e.g., music, art, math, science)

• reactions to sensory assaults; unable to filter out offensive lights, sounds, smells, tastes, touch

• may be argumentative

• stalking behavior

Associated features/comorbidity:

• motor clumsiness, fine-motor impairment, dysgraphia

• difficulty with visual processing, dyslexia

• deficits in organizing and planning (“meta-cognitive”

deficits)

• depression

• Attention-Deficit Disorder

• Obsessive-Compulsive Disorder

When in distress, a student with AS may miss classes or assignments and then not communicate about those absences or missed work. S/he may appear agitated or anxious and become argumentative or exhibit angry outbursts. Some students may appear more disheveled and engage in self-soothing behaviors.

As a faculty member, you can support a student with AS by providing advanced notice when changes are anticipated. Be sure to allow for one or more short breaks in classes that are longer than 50 minutes. Take the time to assist the student with understanding assignments and academic expectations. Consider allowing the student to work alone for assignments that are normally done in groups.

Students with AS are subject to the same regulations governing student conduct that apply to all other students of the university. If inappropriate behavior occurs, address it in private. Describe

the behavior and desired change as well as logical consequences if it continues. Students with AS often don't realize when they are being disruptive.

Ask the student how s/he would prefer you to address behavioral issues in class . For example, establish a cue to use when the student is monopolizing class time that will remind the student to stop the behavior.

Resources:

The Way I See It: A Personal Look at Autism and Asperger's. Grandin, T. 2008.

Thinking in Pictures: My Life with Autism. Grandin, T. 2006.

Unwritten Rules of Social Relationships. Grandin, Temple and Barron. 2005.

Written by Michele Fish, Associate Director, Student Disability Services, Center for Learning and Teaching

Eating Disorders

Eating disorders comprise anorexia nervosa, bulimia nervosa, compulsive overeating, and disturbed eating patterns. They range from mild to life-threatening. Timely treatment for all eating disorders is recommended to avoid worsening symptoms as well as developing long- term complications. Men and women suffer from eating disorders, with as many as one in four young women and one in ten young men meeting the diagnostic criteria for an eating disorder.

Both anorexia nervosa and bulimia nervosa involve a significant disturbance in the perception of body shape and weight, which leads to an abnormal or obsessive relationship with food, exercise, and self-image. Eating disorders sometimes begin with dieting as part of training or preparation for athletic competitions such as wrestling, track and field, or swimming. Anorexia nervosa is characterized by the refusal to maintain minimally normal weight for age and height (weight less than 85 percent expected), an intense fear of gaining weight, a denial of the seriousness of the current low body weight, and amenorrhea in women.

Bulimia nervosa is characterized by recurrent episodes of binge eating followed by inappropriate behaviors to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, and enemas; fasting; and/or excessive exercise.

Other students with eating disorders include restrictive eaters and men with disturbed body image who exercise and take supplements.

Depression, anxiety, and substance abuse often accompany eating disorders. Many students with eating disorders also practice self-injury or consider suicide. If a student's eating disorder jeopardizes his/her physical and emotional health, the student may need to leave school and enter intensive treatment.

Some of the symptoms associated with eating disorders are significant weight loss, the inability to concentrate, chronic fatigue, decreased strength of immune system and susceptibility to illness, an obsession with food that dominates the student's life, extreme moodiness, excessive vulnerability to stress, tendency to socially withdraw, repetitive injuries and pain from compulsive exercise, and excessive perfectionism or rigidity.

When you suspect a student may have an eating disorder, express your concern about the student's health. Refer the student to the Counseling Center which offers both individual and group counseling and works with the Health Center in providing treatment.

Resources:

The National Eating Disorders Association, 800-931-2237, www.nationaleatingdisorders.org

Surviving an Eating Disorder: Strategies for Family and Friends.

Siegel, M. Brisman, J. and Weinshel, M. 1989.

Jane Brody's Good Food Gourmet, Good Food Book, or Nutrition Book. Brody, J., a Cornell alumna and New York Times personal health columnist. 1990, 1985, 1982.

Nancy Clark's Sports Nutrition Guidebook. Clark, N. 1996.

Life without ED: How One Woman Declared Independence from Her Eating Disorder and How You Can Too. Schaefer, J. and Rutledge,T. 2003.

Self-Injurious Behavior

Self-injury is sometimes called "deliberate self-harm," "self-mutilation," "cutting," or "non-suicidal self-injury." Self-injury typically refers to a variety of behaviors in which an individual intentionally inflicts harm to his or her body for purposes not socially recognized or sanctioned and without suicidal intent. Self-injury can include a variety of behaviors but is most commonly associated with intentional carving or cutting of the skin, subdermal tissue scratching, burning, ripping or pulling skin or hair, swallowing toxic substances, self- bruising, and breaking bones.

Detecting and intervening in self-injurious behavior can be difficult since the practice is often secretive and involves body parts that are relatively easy to hide. Unexplained burns, cuts, scars, or other clusters of similar markings on the skin can be signs of self-injurious behavior. Other signs include: inappropriate dress for season (consistently wearing long sleeves or pants in summer), constant use of wrist bands/coverings, unwillingness to participate in activities that require less body coverage (such as swimming or gym class), frequent bandages, odd or unexplainable paraphernalia (e.g., razor blades or other implements that could be used to cut or pound), and heightened signs of depression or anxiety.

Creating a safe environment is critical for self-injurious adolescents or young adults. Avoid displaying shock or showing great pity. The intensely private and shameful feelings associated with self-injury prevent many from seeking treatment. It is important that questions about the marks be non-threatening and emotionally neutral . Evasive responses from those engaging in self-injury are common. However, concern for their well-being is often what many who self-injure most need; persistent but neutral probing may eventually elicit honest responses.

Resources:

The National Self-Harm Network (UK) is a key information resource for young people who self-harm, their friends and families, and for professionals working with them, www.thesite.org/healthandwellbeing/mentalhealth/selfharm

To help students find more information and resources, direct them to the website for the Cornell Research Program on Self-Injurious Behaviors, www.crpsib.com

Understanding Self-Injury-a Workbook for Adults. Connors, R. and Trautmann, K. 1994.

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